Community Service Network 7
DHHS Biddeford Office
November 20, 2006

DRAFT Minutes

Present: Jim Kupel, United Behavioral; Nancy J. Roy, Center for Life Enrichment; Elizabeth Sjulander, Saco River Health Services; Rita Soulard, SMMC; Scott Ferris, Creative Works Systems; Megan Gendron, Jen Ouellette, York County Shelter; Kendra Williams, Goodall Hospital; Anita Jones, Community Mediation Services; Chris Souther, Shalom House; Mark Jackson, Harmony Club; W. C. Martin, Common Connections; Karl Wulf, Common Connections; Jeanne Mirisola, NAMI-ME; Sherry Sabo, Jennifer Goodwin CSI; Mary Jane Krebs, Spring Harbor; Ron St. James, DHHS. Presenters from OAMHS: Ron Welch, Leticia Huttman, Don Chamberlain, Marya Faust, Carlton Lewis. Muskie School: Janice Daley, Elaine Ecker.

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I. Welcome and Introductions	Carlton Lewis, Region I Team Leader, welcomed everyone to the meeting and introductions were made around the table. He briefly reviewed meeting materials and explained the format of the meeting, i.e. that questions may be posed at any time during the presentations. Any questions requiring significant time to answer will be recorded in the "parking lot" and addressed during that part of the meeting.	
II. Overview of the Mental Health Plan approved by the Court Master on October 13, 2006.	Ron Welch, Director of DHHS Office of Adult Mental Health Services (OAMHS), thanked everyone for attending and informed members that this meeting presentation is unusual in that most of the meeting will involve a presentation of the overview of the Consent Decree Plan, signed on October 13, 2006; however, in the future the meetings will be more interactive. He focused on Chapter 4 of the Plan, Continuity of Care and Services, which includes the formation of Community Service Networks (CSNs) and mentioned that this plan was approved with very tight timelines. The entire program was accompanied by a comprehensive PowerPoint presentation. Handouts were distributed to everyone present. Ron explained the 4 major components, which he calls "The Four Cornerstones", of Chapter 4 of the Plan that discusses continuity of care. They appear below as A, B, C, and D. He emphasized that all four pillars are founded in the concept of recovery with new emphasis on vocational services as part of the underpinning.	
	A. Seven Community Service Networks.	• The state is divided into ***7 CSNs*** (see chart on website). Ron mentioned that these areas are contiguous with the old community mental health centers service areas. • Each CSN provides ***8 core services***: Peer Services, Crisis Services, Community Support Services, Outpatient Services, Medication Management, Residential Services, Vocational Services, Inpatient Services. He explained that all services must be provided in the CSN; however, they may not be offered in all parts of the network area. Peer services are a new and important part of the listing of services. • ***Functions*** of CSNs: ‣ Assure delivery of services to all adult mental health consumers in the network area. ‣ Maintain a "no reject" policy so that no consumer is refused needed service within the CSN area. Ron explained that the no reject policy has caused consternation and he wants to make sure that people understand what this policy means. Ron explained that the "no reject" expectation pertains to the network as a whole, not to individual providers. He distributed a letter of clarification to CSN members, and stated that he believes that this provides a reasonable interpretation that passes muster with the Attorney General's Office. He suggested that members attach this letter to their contracts or the MOU.

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		‣ Engage in problem solving in the CSN to ensure that clients with complex needs are appropriately served. Ron explained that the goal is to have the CSN look at needs and develop capacity. ‣ Identify services necessary for consumers in the CSN who are at risk and provide those services. ‣ Comply with all provisions of the Bates v. DHHS Consent Decree, especially where service coordination within the core service array is necessary. ‣ Assess and identify resource gaps by geographical area and establish remedial measures and implementation timeframes. Ron explained that Marya will discuss tools and mechanisms to make this a reality. ‣ Assure 24-hour access to a consumer's community support services' records for Community Integration (CI), Intensive Community Integration (ICI), and Assertive Community Treatment (ACT) for better continuity of care during a psychiatric crisis. **Question:** When doing a gap analysis, if there is an overabundance of services amongst the providers of the CSN, would providers be asked to change what they're doing? **Answer:** Recommendations regarding reutilization of funds may be an appropriate response. By and large there are enough resources in the state and the financial planning and budgeting for the Network belongs here. It would be a recommendation of the CSN. ‣ Plan based on data and consumer outcomes. Ron commented that in the past plans haven't always been able to plan based on data, but on anecdote. ‣ Implement the Rapid Response protocols. ‣ Provide coordination among the community support program, the crisis program and hospitals to ensure the appropriate sharing of information, including the ISP and community support worker attendance at hospital treatment and discharge planning meetings. Ron stated that he doesn't like the word discharge, but that it is more accurately called transition as people go back into the community. ‣ Assure continuity of treatment during hospitalization and the full protection of a client's right to due process. ‣ Recognize the authority of the community support services staff (CI, ICI, ACT) as coordinators of the ISP and the services contained therein. Ron emphasized that the community support staff have definitive responsibilities in this Plan that must be recognized.
	B. Performance Requirements/ Enforcement through contracts.	• **Contract Amendments** were mailed to all providers with OAMHS contracts. The amendment must be executed by November 19, and requires operational protocols and a Memorandum of Understanding finalized and approved for each CSN by January 3rd. Termination provisions for non-adherence are outlined in the Plan; and, Ron added, "the Court Master is adamant about this." If a plan of correction is not lived up to, action will have to be taken. • **Legislation** is expected to define CSNs, assure momentum, and provide [system] consistency with managed care. • **Quality Management Structure** ‣ Replace monthly provider meetings with network meetings. ‣ Provide data by agency and by network. ‣ Problem-solve within network, with local consumer council. Ron mentioned that the OAMHS will provide this data to the network and will be able examine this for planning purposes. The topic of data points and what is important was added to the parking lot. Ron also noted the major differences between the CSNs and the former LSNs: 1) Managed by OAMHS, 2) Action will be driven by data, and 3) CSNs are explicit in the Court Order.

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		• **Realignment of Services** Community Support Services: ‣ Each consumer will have CSW to coordinate their ISP and crisis plan; locate, obtain, facilitate, coordinate, monitor services. Ron explained that this resource is not there for everyone and some consumers do not want a CSW. This may require a new request to the legislature. ‣ CSW's employer is the lead agency for the client. ‣ Providers must assure 24/7 access to: ISP, Crisis Plan, health care advance directives, contact information for prescriber, and basic demographic and service information. Ron stated that this doesn't mean that the CSW has to stay awake all night waiting for a call, and that there a lot of ways to accomplish this. It is important the ER doctor has access to this information. Crisis Services: ‣ Provided outside the Emergency Department, unless: consumer requests otherwise, medical condition need treatment, or person is in protective custody of the justice system. ‣ Consumer's CSW is responsible during business hours. Ron explained that this really means that this information is made available to the CSW. The CSW makes this information available to the crisis worker, unless the person is in an ACT team, which is defined by 24/7 services. ‣ During non-business hours, crisis service is responsible, unless consumer is enrolled in ACT. ‣ In Emergency Department, crisis provider must: assess for less restrictive alternatives to hospitalization, locate and arrange for those services, and review crisis plan and advance directives. Hospital Services: ‣ Community hospitals are the first level of hospitalization response. MaineCare amendment will assure no-reject policy. Ron informed the group that the no-reject policy raised a fair amount of discussion at the last CSN meeting. He explained that they're talking about making every reasonable attempt to accommodate everyone, and that this is a burden for the Network. The OAMHS is consulting with the Attorney General's Office and will clarify this in writing as soon as possible. ‣ Specialty hospitals, Acadia and Spring Harbor, are the next line of treatment. They will take admissions from community hospitals. ‣ Public hospitals, Riverview and Dorothea Dix, will take referrals from Spring Harbor and Acadia, as well as forensic admissions. Ron explained that the public hospitals typically take admissions from the specialty hospitals. He directed members to page 27 of Section I of the CSN Reference Notebook, to the section on Unusual Circumstances. This explains why this process is not always linear, but the idea is to have some hierarchy while maintaining some flexibility in the system.
	C. Permanent Housing with Flexible Services	**The current link between services and housing will be broken. Only residential treatment will remain as a group home model or bundled service.** Ron explained that they want to break the link between housing and services now linked in PNMIs that are defined by the highest level of need. There is a need to restructure Section 17 and PNMI. Don Chamberlain is convening a work group to look at the amount of flexibility in PNMIs, so as to provide people with what they need, when they need it. Ron has had discussions with providers who believe that the PNMI program can offer this flexibility.

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		PNMI is currently the major choice for residential treatment: • This model requires the highest level of intervention for all residents, irrespective of need. • A needs assessment for this level of care will be undertaken to determine where and how many beds should be retained. • For those beds remaining, long-term stay is not the goal. • Successful treatment and re-entry into community life is the goal. **Question:** Will this affect a lot of people? **Answer:** That may be the case. There are a number of people in models of PNMI where the issue of flexibility of services is already met. Work group meetings will reveal how much alteration is needed. Ron summarized by explaining that the consumer "gets a home and 3 squares, and the treatment piece will come from various funding streams, wrapped around the person," providing maximum flexibility whether they need 24/7 care or only home visits for medication management. Housing Options and Resources: • Units developed with support of DHHS • BRAP • Shelter Care Plus vouchers • OAMHS will develop housing database
	D. Consumer Councils and required peer services.	Ron informed members that Leticia will discuss this cornerstone in the next part of the presentation; however, he believes that this cornerstone will effect the strength and tenacity of the system. "In my judgment, never before has the consumer presence meant so much, and it will only become stronger." • Through 3rd supplemental budget of the 122nd Legislature, a mandate with $323,000 was passed to establish consumer councils statewide. • A Transition Planning Group was formed with representation from virtually all segments of the consumer community. • That work is underway and will be presented as part of this program • This particular cornerstone will affect the strength and tenacity of all of the others. • It will undoubtedly have more impact in how the Maine mental health system delivers services than any other.
	Vocational Services	Ron explained that this is the biggest issue for the Court Master. • Vocational services are absolutely pivotal to successful recovery. • 2 benefit specialists and 4 employment specialists will be out-posted across the state. • Each will produce work for a percentage of their caseload—15% is the expectation, Ron said. • Training will be provided to over 525 CSWs across the state, as to the critical importance of work in the recovery process. CSWs are not employment specialists, Ron explained, but they should think in terms of work for their clients. • DHHS entered into an MOU with the Dept. of Labor and Bureau of Rehabilitation Services outlining the respective responsibilities of each. (Both Departments are named defendants in this litigation.)

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		• Employment specialists, as required under the fidelity standards of ACT, will be required to show evidence that, in fact, their entire focus is dedicated to work. Ron stated that fidelity standards don't require 100% focus on work by ACT team, but 8%. **Question:** What if they want to finish college? **Answer:** With that issue we would work with the Dept. of Rehabilitation. The MOU sets the stage for including continuing education. **Question:** May we have a copy of the MOU? **Answer:** Yes, we'll email the MOU to everyone.
III. Consumer Council and Consumer and Family Representation	Leticia Huttman, Director of the Office of Consumer Affairs, presented this part of the program. **Development of Statewide Consumer Council System** The development of the consumer council system began in April 2006 when the Transitional Planning Group (TPG) began to meet. The TPG is comprised of consumer leaders, meeting biweekly in a facilitated process. Their mission is to develop the basic elements and structure of the independent Statewide Consumer Council system. Leticia stated that the group of consumers was chosen from various stakeholder groups, and their mission is to be independent. The TPG has developed a timeline, as follows: • April 2006 – TPG begins meeting • March 2007 – 3 Regional Conferences • May 2007 – Form at least 3 temporary regional councils • June 2007 – Statewide Council seated and holds first meeting • August 2007 – 7 Local Consumer Councils formed The TPG has hired a coordinator and three outreach workers, whose work will include getting people involved and excited. Dee Clark is the outreach worker for the Biddeford area. They will be contacting providers and meeting with consumers/groups throughout the State. The draft design of the system consists of multiple tiers: Temporary and Periodic Regional Councils, Statewide Consumer Council, and Local Consumer Councils. The Temporary and Periodic Regional Councils will basically operate until the Statewide and Local Consumer Councils are formed, fading over time as this happens. Eventually, many Local Councils will be functioning throughout the State. They will be comprised of consumers from a wide variety of settings: Peer support programs, peer centers and social clubs, provider agencies, hospitals, at-large consumers, homeless shelters, club houses, and other places yet to be thought of. The Local Consumer Councils are designed to be inclusive and will include people with a wide variety of experiences. The meetings will be held in the form of town meetings, where all can contribute. The members or officers will be chosen based on an application process to be sure a diversity of experiences is represented. The Local Councils will elect representatives to send to the Statewide Consumer Council. Functions of Local Consumer Councils: • Have a role in meaningful quality assessments • Advocate/advise for local response to local issues • Report with representation to the full Statewide Consumer Council system • Receive and transmit information from wider world • Outreach for concerns beyond our members • Regional work to create and support local council efforts	

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	Leticia reported that the TPGs sent out applications for consumers to be in CSNs now, so that consumers can be represented while the CSNs are being developed. She also commented that the TPG realizes that not everyone is a joiner; however, having a voice doesn't mean you have to sit at the table to be heard. Mission and Function of Statewide Consumer Council: • Provide one-stop access for advice and planning on issues affecting lives of consumers • Advice directed to and developed with DHHS and also to other departments and administrations • Opportunity for consumers to learn from one another and to increase the impact of advice offered The Council will provide a way to learn, grow, and to become more skillful and knowledgeable as consumers and we will see the impact in individual provider agencies. • Support consumer-advising skills and develop interest in the Council system. • Develop/implement and oversee quality assessment of services and delivery systems in order to ensure quality services and participate in effective design. Leticia commented that the OAMHS is excited about having more consumer involvement in quality assurance, and that this is a way to move forward and a wonderful avenue for partnership. **Consumer and Family Participation in Community Service Networks** Consumer representatives in the CSNs will come from two places: Each local council when formed (TPG representation in the interim) and from all peer centers/social clubs within contracted agencies or contracted independently with OAMHS. Making sure consumers are included from various venues throughout the process demonstrates that the Department is making a serious shift away from "tokenism," Leticia added. OAMHS will also offer some technical assistance to give consumers tools to engage in process. NAMI-ME is also providing a family member to each CSN to represent the concerns of families with adult family members who are living with mental illness.
IV. Community Service Networks: Implementation Plan, Memorandum of Understanding, and Operational Protocols	Don Chamberlain presented the details of the CSN Implementation Plan, MOU, and Operational Protocols. **CSN IMPLEMENTATION PLAN** **Development Timeframe** • Immediate deadlines are signing the contract amendments by November 19 and executing the MOUs and Operational Protocols by January 3. During November and December CSN participants will give input on roles, expectations, responsibilities, and develop MOU and Operational Protocols, signing both documents no later than January 3. Don reported that they are close to having 100% of contract amendments, and that the amendments, MOUs, and protocols are the big pressure points. He emphasized that the dates in the plan are extremely important to everyone. Meeting these deadlines shows the Court that we're committed to compliance. • Over time with input from all parties: Statewide Policy Committee and monthly network meetings. By February 2007, CSN work plans will be created and CSNs will select participants for the State-Wide Policy Council in January. Participants from each CSN: consumer, community support services provider, crisis services provider, hospital provider, and vocational provider. **State-Wide Policy Council** This council will be convened by OAMHS in February 2007 and will be directed by OAMHS senior management. Duties and timeframes as follows: Don informed the group that they are pushing the date to select participants back to January.

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	• Managing dynamics of network responsibilities. (February) • Assessing compliance with "no reject" policy. (March) • Assessing 24/7 CSW access. (March) • Review resource gaps and make recommendations. (March) • Develop and implement network-level planning tools. (May) • Identify all QA and QI performance measures that will become purview of CSNs to monitor and report on to OAMHS. (May-June) • This includes QA and QI processes and protocols that CSNs will use for review of data and recommendations to OAMHS. (May-June) • Develop CSN performance review process. (July) Question: Is the State-wide Policy Council going to meet monthly? Answer: Yes. **MEMORANDUM OF UNDERSTANDING** Don explained that OAMHS is gathering any and all suggestions for changes to the MOU and operational protocols and these will be on the agenda for the December meetings of the CSNs. The process for taking input is via email to Elaine Ecker (eecker@usm.maine.edu). He expects that one MOU and one set of Operational Procotols will be developed for all CSNs to meet the requirements of the Court. He noted that it is possible to revisit these documents in the future through the amendment or other process. The MOU, as currently drafted, (and distributed in various mailings and in the Consent Decree Quarterly report), contains the following elements: **Goals of CSN** • Provide integrated system of care • Core services available in area • Consumers' changing needs met seamlessly • Improve continuity of care, efficiency, outcomes, cost effectiveness **Guiding Principles** • Focus is adult mental health consumer • Quality of care depends on access and transitions without disconnection. Don emphasized that he likes to think of these as transitions, and not as discharging. • Coordination makes effective, responsive system • Local planning, local problem solving, and a mutual understanding of the roles and expectations of each services provider should be effective ways to support continuity of care. CSNs are all about being local, Don said. • Based on current best practices and evidence based models, the mental health system must support consumers becoming knowledgeable about their condition, the availability of services, and self-directed regarding services. Don emphasized that this is the cornerstone of all of our endeavors and is critically important. • Providers and systems practice collaboration across disciplines, including peer disciplines, and health specialties. **Structure of CSN** • Meet at least monthly • Establish and oversee operational protocols

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	• Establish outcome measures and assure quality • Establish sub and ad hoc committees, as necessary • Chaired by OAMHS **Agreement and Responsibilities** Each member agrees to: • Assure delivery of services to all adult mental health consumers in the network area. • Maintain a "no reject" policy so that no consumer is refused needed service within the CSN area. Don stated that they are not saying that everyone has to go internally (within their CSN), but most will. An example of a person who may not use a service in their CSN is someone who lives nearer to a hospital in another CSN than in their own. • Engage in problem solving in the CSN to ensure that clients with complex needs are appropriately served. • Identify services necessary for consumers in the CSN who are at risk and provide those services. • Comply with all provisions of the Bates v. DHHS Consent Decree, especially where services coordination within the core service array is necessary. • Assure 24-hour access to a consumer's community support services' records for Community Integration (CI), Intensive Community Integration (ICI), and Assertive Community Treatment (ACT) for better continuity of care during a psychiatric crisis. Question: Who's giving permission to access consumer records? I am concerned about this. • Plan based on data and consumer outcomes. • Implement the Rapid Response protocols. • Provide coordination among the community support program, the crisis program and hospitals to ensure the appropriate sharing of information, including the ISP and community support worker attendance at hospital treatment and discharge planning meetings. • Assure continuity of treatment during hospitalization and the full protection of a client's right to due process. • Recognize the authority of the community support services staff (CI,ICI,ACT) as coordinators of the ISP and the services contained within. The participant will: • Appoint a representative who has the authority to make commitments on behalf of the participant and who will attend monthly meetings of the CSN. • Join in appropriate special projects and committees may be developed by the CSN. • Commit to the guiding principles, goals, and structure outlined above. Don again asked members to send recommendations for changes to the MOU to Elaine or bring to the December meeting of the CSN. **Question:** With wording like "member agrees to support 24/7", is there an assumption that all who sign will do this? My concern is the 2 a.m. call—who will actually be responsible? **Answer:** We all are. 24/7 is a contract compliance issue with OAMHS, which includes a process to address any non-compliance. **Question:** Where/who do people call at 2am [for consumer's treatment information]? **Answer:** The ER doctor would have to talk to the consumer and/or the family, get permission, and then contact the CSW to get information. If a consumer doesn't have a CSW this is a resource gap, and we haven't resolved this yet. Ideally, information would be provided in advance of a crisis and some have done that. **Question:** Does this apply to all consumers of Adult Mental Health Services?

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	Answer: Yes, for all consumers of AMHS who meet the criteria of Section 17 of MaineCare. Some have discussed non-categoricals, those people who have been found to be eligible for some services, but not all. We need some good information about this. **OPERATIONAL PROTOCOLS** **Purpose and Goals** • Same as listed under MOU "Goals of CSN" above. **Membership** • Each provider required to designate a representative. • Representative must be able to speak for organization. • Consistent representation is expected. • Not intended to be rotating designees. • Substitute designees may discuss, but not vote. *Eligibility*: • One representative from each provider with contracts with OAMHS who provide any of the core services. • One representative from each community hospital, with and without psychiatric units. • One representative from the psychiatric specialty hospital and from the state hospital. • One to three consumer representatives chosen by the consumer-run Transition Planning Group (eventually replaced by Consumer Council representatives). • One representative per social club or peer center, if part of a larger agency contracted to provide more than peer services. • One representative from NAMI-ME. • One representative from Community Mediation Services. *Service Array*: • Eight core services *Chairperson*: • Senior staff member of OAMHS. Don explained that this is not negotiable. *Changes to Membership*: • May change depending on needs of CSN and changes in services/providers in CSN area. Don commented that people have asked about providers of other services such as substance abuse. He stated that these may be added over time. *Decision Making*: • Each member has one vote—vote shall be recommendation to OAMHS. **Meetings** *Regular:* • At least monthly, more often if necessary. • Scheduled by OAMHS. Don stated that the OAMHS will take care of scheduling, meeting notices, facilities, and other logistics for these meetings. *Special*: • Called by OAMHS on its own or at the request of majority of membership. *Notice*: • Notice given to each member not less than one week prior.

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	Quorum: • Discussion and recommendations take place with those members present. *Voting*: • CSN decides on issues it shall vote upon. • Decided by simple majority of those present. • Advisory to OAMHS unless OAMHS states it will act on the vote. *Attendance*: • Absence from 3 or more consecutive meetings shall be reason for contract or provider agreement review. Don explained that typically Boards remove members who miss three consecutive meetings; however, this will not be the case. This will result in a discussion with the provider. *Agenda*: • Set by OAMHS with input from membership. • Include time set aside at each meeting for public comments. Don commented that members may want to invite others with burning issues. **Ad Hoc Committees** • CSN may designate ad hoc committees. • Chair will appoint committee chairs. • Committees will report to full CSN. Don explained that they are trying to make all action happen at the CSN. **Amendments** • CSN may amend the operational protocols from time to time. • Proposed amendments must receive majority vote of members present. • Proposed amendments must be approved by OAMHS before acceptance. **Question:** If and when the State develops a managed care contract, there may be an overlap between the MCOs and the CSNs. **Answer:** There are two things operating. One is a response to the Consent Decree, and the other is the development of a managed care system. In the past they have said that managed care will take care of some of these issues, and when the implementation of managed care was postponed, the Department was out of compliance with the CD. Since there have been delays with the implementation of managed care, we have decided to develop a system that works and have the managed care organization work within this to be in sync. **Question:** When will managed care be implemented? **Answer:** The Department has not committed to a date. We have discussed July 2007, but not committed to this. We need to go ahead and be in compliance with the Court.
V. Consent Decree Standards: Indicators for Performance	Marya Faust, Director of Policy, gave an overview and explanation of the Performance and Quality Improvement Standards that are part of the approved Consent Decree Plan. • 34 standards were negotiated with the Court, the Plaintiffs, and OAMHS. They will not change. They are grouped under 12 categories. • OAMHS reports on these standards quarterly and all documents included in the reports are posted on OAMHS website. (The documents for the most recent quarterly report were included in the notebook provided to each attendee at this meeting.) • Riverview Psychiatric Center has its own set of measures, also included in the quarterly reports. Dorothea Dix was not a party in

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	the Settlement Agreement, so it is not part of this reporting process. • Some standards are measures of all people using the services and some are just for class members. Marya pointed out that the appendix section specifies who is included in the data and how the data was derived. • Anyone who was a patient at AMHI on or after January 1, 1988, is a class member. This provision extends to Riverview, and each new admission becomes a part of the pool of class members. The number continues to grow. • The standards present a picture of how the mental health system is operating. Marya said that OAMHS will be consistently focusing on this picture "to see how we're all doing." Meeting performance standards does not translate into "compliance," Marya explained. Being in compliance involves a separate process, an additional step, which will be negotiated with the Court Master and Plaintiffs. She gave the following example of a current *performance standard* and an example of a possible *compliance standard*: *Performance standard:* "Class members report in the class member survey that they are informed about their rights as MH consumer in a way they could understand." (Currently the measure is 81.3% and the performance standard is 90%.) *Possible compliance standard:* "For three full quarters, the standard is at 90% or better." Marya reviewed the contents of the notebook provided to all attendees: It contains the full Consent Decree Plan approved October 13, 2006; and the November 1, 2006, Quarterly Report with all attachments. One of those attachments is the Performance and Quality Improvement Standards. Each Standard is listed, with data, and a graph depicting the baseline measurement, the performance standard required by the Consent Decree Plan, and the current measure. Marya discussed several of the standards, as follows: **Standard 1: "Treated with respect for their individuality"** The 2004 baseline shows 91.8%, the current measure is 92.3%, and the performance standard is 90%. "We're all doing well on this standard and deserve a pat on the back," Marya said. **Question:** What about consumers who aren't in a position to speak for themselves? For example, my son who been in and out of the hospital? He has no desire to complete a survey. Would it be a bad idea to send a survey to a family member? **Answer:** We do send some surveys to family members, depending upon the category, since we realize that some people may not wish to answer or be in a place to answer. What we need to do is figure different ways to collect information. We're interested in ways to improve the return rate. **Standard 18: "Continuity of Treatment is maintained during hospitalization in community inpatient settings"** The 2004 baseline shows 31.6%, current measure is 0%, and the performance standard is 90%. "Clearly, we must improve our performance here." Marya pointed out that this information is collected from UR nurses, and the ISP must be included in the record to be counted. A telephone conversation about the client/ISP does not count in the performance calculations. She also said that some standards may not correspond with nationwide performance standards, some were set higher by the Court Master. Performance levels as specified are what is expected.

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	Standards 26 & 27 – Vocational Employment Services Both standards show current measures well below expectations of the Court. The Consent Decree Plan places great emphasis on vocational services and improvements must be made. Marya also discussed other items in the packet and notebook as follows: **CSN Related Components Matrix** • Shows tasks and timelines related to the CSNs. • Excerpted from the overall Consent Decree Plan matrix attached to the November 2006 Quarterly Report. (Included in the notebook at Tab 2.) • Provides a quick reference to what needs to be done and when. **Contracted Services by Network Matrix** • Another attachment to the quarterly report, included in the notebook (Tab 7). • Starting point for identifying what services are provided by providers in each CSN area. • OAMHS will continue gathering information to update this matrix through RSVP forms each member received, as well as an electronic survey Muskie will develop and send out to all members to get more detailed geographic information and enable actual mapping of services. This needs to be completed by January. • This information is critical in identifying gaps and making remedial recommendations, as well as supporting budget requests to the Legislature. **OAMHS Website: Consent Decree** • All Consent Decree documents and quarterly reports are posted in electronic form. • Will add a Community Support Network section to post minutes and other documents and updates. Marya reminded members to send comments related to the operational protocols and MOU to Elaine Ecker at the Muskie School, eecker@usm.maine.edu.
VI. Parking Lot Items	• Do all of the CSNs have all of the 8 core services at this time? • If there is an overabundance of services amongst the providers in the CSN, will the CSN be involved in the re-utilization of resources as needed? • Will education be considered under the MOU between the Department of Labor and the DHHS/ OAMHS? • Who will hold providers accountable for MOU compliance? • Will substitute designees be able to vote? • How do you see the CSN functioning with the MCO? • What if a consumer is unable to respond to a survey that is sent by the OAMHS? .
VII. Next Steps	Carlton informed the group that the parking lot will be typed, and any suggestions for changes should be forwarded to Elaine Ecker at eecker@usm.maine.edu. **Question:** Who from the OAMHS will come to meetings?

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	Answer: This entire OAMHS management team will be at the December meeting, and after that probably one senior manager will attend along with the Team Leader. **Question:** Will there be continuity? **Answer:** Yes. It is important to be consistent. Ron reminded members that future meetings won't involve being 'talked at' so much, with the expectation of much more opportunity for member participation.
VIII. Agenda for December Meeting	• Development of MOU • Development of Operational Protocols • Selection of Policy Review Committee • Service Matrix, Mapping